Exhibit E
Annual Self-Certification Form

CALIFORNIA HOUSING FINANCE AGENCY (CalHFA)
Mental Health Services Act (MHSA) Housing Program
Annual Self-Certification for Special Needs

County: _____
Project Name: _____
MHSA Loan # _____
Cert. of Occupancy or Notice of Completion Date _____

Self Certification Report Period from: _____ to _____

Contact Information:

Project Sponsor		Phone:
Primary Service Provider		Phone:

1. Changes During Report Period:

Please check applicable items. For each checked item, please attach all letters, notes, correspondence and/or written notices documenting the change.

- ☐ New sources of service funds
- ☐ Service funding increases or decreases
- ☐ New service partners
- ☐ Service partner cancellation
- ☐ Service program enhancements or reductions
- ☐ Other planned service program modifications
- ☐ Primary service provider staffing changes
- ☐ Service funding source cancellation
- ☐ Non-renewal of service funding sources
- ☐ Non-compliance with other lenders' Regulatory Agreements
- ☐ Non-compliance with rental subsidy contracts
- ☐ Non-compliance with services contracts
- ☐ Extension of rental subsidy contracts
- ☐ Termination of rental subsidy contracts

2. Subsidy Sources:

Total number of units with rental subsidy contracts: _____

Years remaining on current rental subsidy contracts (please list):

Type of Subsidy	Number of Units	Years Remaining

3. Current Resident Information

Total number of units in project	
Total number of MHSA Housing Program target units in project	
Total number of MHSA eligible residents in project	
Total number of persons residing in MHSA eligible units	
Total number of MHSA housing units receiving COSR	
Total number of MHSA units with an individual Section 8 voucher	
Total number of MHSA units with a project based Section 8 voucher	
Total Number of MHSA eligible residents receiving SSI	

4. During this Report Period: MHSA Eligible Residents Who Have Left the Housing

(Show the number of permanent **(P)** and temporary **(T**) departures)

P	T	Reason for Leaving	P	T	Reason for Leaving
		Hospitalization			Death
		Moved to a licensed facility			Other
		Moved to more independent housing			
		Eviction			
		Jailed			

Total number of temporary departures _____

Total number of permanent departures _____

Provide the following for each MHSA eligible resident who permanently departed from an MHSA unit: 1) Length of residency, 2) Income level at termination of tenancy.

Explanation(s):

5. During this Report Period: MHSA Resident Demographics
Enter the number of MHSA eligible residents in each category (may be duplicated)

☐	Living alone	☐	Chronic health condition
☐	Living with other(s)	☐	HIV/AIDS
	☐ Children ☐ Spouse ☐ Unrelated persons	☐	Substance Abuse
		☐	Other serious medical condition

6. During this Report Period: Housing status at rent-up

Total Homeless: _____

Total At risk: _____

7. Total MHSA Priority Populations in project:

Older Adults: _____
Adults: _____
Transition age youth: _____
Children: _____

Total MHSA eligible residents enrolled in Full Service Partnership (FSP) services: _____
Total number of MHSA eligible residents who are veterans _____
Total number of tenants who are veterans _____

8. Service Providers (please attach additional pages if needed)

Please list requested information for all service providers, whether individuals or organizations/institutions, and whether the service provider provides services on site or off site:

Provider Name	Address	Phone Number	Contact Person	On-Site	Off-Site
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐

9. Supportive Services---Resources and Utilization

Indicate the services that have been offered to the MHSA eligible residents in this project during the reporting period. Also, indicate if these services are offered on-site or off-site, and the frequency of the service (times per week, per month, as needed, etc.):

Service Type	On-site	Off-site	Frequency
Service coordination	☐	☐	
Case management/crisis intervention	☐	☐	
Mental health services	☐	☐	
Substance abuse services	☐	☐	
Peer facilitated groups/activities	☐	☐	
Medication education/support	☐	☐	
Life skills	☐	☐	
Employment/vocational services	☐	☐	
Tenant association/council	☐	☐	
Benefits counseling	☐	☐	
Social/recreational activities	☐	☐	

AA/NA groups	☐	☐	
Primary care: Health screening, assessment, education	☐	☐	
Other:	☐	☐	

Provide a narrative description of the strengths and challenges in the supportive services program during this reporting period:

10. Supportive Service Budget Information

Please provide budget information for your previous and current fiscal years, including costs of staff and services combined:

Previous year budgeted funding level (FY:)	$
Previous year actual funding level (FY:)	$
Current year budgeted funding level (FY:)	$

Certification of Accuracy of Information Provided

I hereby certify that the information provided in this "Annual Self-Certification for Special Needs" is true and correct, and reflects the status of the _____ project as of the date of this report.

Signed by: _____ Date: _____

Title: _____

Organization: _____

Certification that a copy of this report has been sent to CalHFA, the State Department of Mental Health and the County Mental Health Department at the addresses listed below.

Signed by: _____ Date: _____

Title: _____

Organization: _____

Mailing Addresses:

California Housing Finance Agency
Asset Management Division
Attn: Abe Tsadik
100 Corporate Pointe, Suite 100
Culver City, CA 90230

California Department of Mental Health
Attn: Jane Laciste
MHSA Plan Review and Community Program Support Section
1600 9th Street, Suite 150
Sacramento, CA 95814

_____ **County Mental Health Department**

Contact Name: _____
Street: _____
City/State/Zip: _____